NAME/ADDRESS CHANGE

For name/address change, please complete this form and submit a copy of identification with your current name. (For example, a copy of your social security card with current name, Driver's License with current name, Marriage License, or Divorce Decree, whichever applies).

Please indicate license type and number:

_____Speech-Language Pathologist

_____Audiologist

_____Dietitian

_____Adult Care Home Administrator

Social Security Number: _____ Birthdate:_____

Name_____
(Last) (First) (Middle)

Previous Name: _____

Current Mailing Address: _____
(Street) (City/State) (Zip)

Phone Number (Home) _____ (Work) _____

(Cell)_____

A printable verification of your license which would verify your new name can be obtained at no cost at www.kdhehealthlicense.org

If you would prefer a new pocket card be printed please indicate below and include payment in the amount of $10.00 payable to "KDADS."

_____I am requesting a new pocket card be printed and have enclosed the required $10.00 fee.

Signature Date